Contemporary Themes

Explaining death to children

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"Neither the sun nor death can be looked at with a steady eye."—LA ROCHEFOUCAULD 1613-80.

It is important from the outset to dispel the myth that discussions about topics such as death, bereavement, grief, and mourning will inevitably be gloomy. Parkes[1] has observed that, just as books on the psychology of sex are seldom pornographic, investigations into death and bereavement are not of necessity doleful. The following paragraphs are intended to help health professionals and teachers who are considering talking to children about these subjects, by providing some background information on death, bereavement, and the subsequent period of mourning.

Death may be defined quite simply as the end of life. Bereavement may be taken to mean the loss of something but it is most often used in the context of the loss of a person through death. Grief is the experience of deep sorrow while mourning is the expression of that sorrow after bereavement. If we are to explain death, bereavement, and mourning to children we will need to know more than these straightforward definitions, for each category presents a complex array of issues.

Death

People's views of death may vary. It may be the natural enemy of all living,[2] or it may be a fortuitous event.[3] The phrase *mors certa hora incerta* (the most certain thing in life is that we will die), however, expresses succinctly the fact that death is the one inescapable event in our existence. Although we can live in the expectation of death, dying is something that many people fear, despite the various religions which attempt to allay this fear by promises of immortality. The hope of the living is to extend the period of enjoyable and useful life. Without death, there would be no facility for change or development. We must therefore accept that death is both a biological necessity and an inevitable fact if life is to continue.

Death—the child's view

One of the most comprehensive studies concerning children's ideas about death has been documented by Anthony.[4] She concluded that children under the age of 4 or 5 years tend to ignore the phenomenon or else respond with a puzzled and maybe even callous interest. At this stage in early childhood both death and absence have the same effect. Between the ages of 5 and 8 children become more intrigued with death, but they may associate it with aggressive feelings of fear and guilt because they often believe that it is a punishment for their own misdeeds. At this age they may also believe that death is reversible. Children begin to have a rational understanding of death when they are 9 or 10.

How does death affect children?

It was commonplace for children in the past to have experienced death within the context of their own homes. Today infant mortality is low, people live longer, and the incurably sick generally die in hospital. But, because the patterns of dying have changed both qualitatively and quantitatively, it does not mean that children are affected less. Television communicates death to children in a very vivid way, but has it helped them to understand what death really means? Mitchell[5] suggests that the traumatic experience of the breaved has not altered and it may have been intensified. If this is true perhaps children should be prepared for the possibility of death and bereavement before such events occur. Teaching the concepts of death and bereavement to children in school could be one solution to a difficult problem. It may be argued, however, that few children are affected by the trauma of bereavement caused by a death. This may be so but adults, particularly health professionals and teachers, should be concerned with the needs of the individual child. Catering for the minority is an essential part of our role.

The death of a parent is more likely to affect children than the death of a distant relative. In the animal world the bond between parent and offspring is called the attachment reflex; in people this same reflex is often referred to as love. The attachment of a child to its mother is at first for protection, later developing into the mating attachment that in some species endures for a lifetime. Brown[2] states that "frustration of the attachment reflex or loss of the loved one becomes in fact as dire a threat as death itself, for this is depression, the most unpleasant effect or emotional term which human beings can endure, and in childhood, when protection is needed, this loss is perhaps more profound than at any other time." It may be suggested that this fracturing of love could be more harmful than the fracturing of a bone. In both instances healing is essential. If love is neglected, however, the mental health of the bereaved person may be affected irrevocably.

Bereavement

Bereavement may be defined as the forcible loss of something that is precious.[6] This word is most often used in the context of the death of a person but it may include, for example, the loss of an inanimate object or the ending of a relationship. The distinction between the trauma of bereavement and the deprivation that may follow is well worth making. Deprivation is something that can be remedied but the bereavement itself cannot—although it can be treated sympathetically.

Children are often concerned in some form of loss at an early

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age. The mobility within society today may mean that families move to different homes more often than in the past, thus early friendships are lost. Children of service families often experience the absence ("loss") of the father. This may be temporary, but to the young child it can have the same effect as a more permanent loss.

Anthony[4] found that children react to death and bereavement in differing ways according to their stage of intellectual development as defined by Piaget.[7] Bowlby[8] supports this view and further suggests that early childhood reactions to separation from the mother can be equated with mourning after bereavement. He outlines three phases of separation reaction—protest and angry crying; depression, apathy, withdrawal, and despair; and, finally, complete detachment from the absent mother. This last phase occurs when a young child is separated from its mother for a month or more. Bowlby's emphasis is on the bereavement trauma itself, the memory of what has been lost rather than the lack of parental influence.

There are few scientific studies of the ways in which people cope both with death and with mourning. This is probably in deference to the vulnerability of the bereaved. It appears, however, from the evidence that has been collected that the harmful effects of bereavement, especially on children, are more often due to its long-term social consequences and to the emotional reactions of the surviving parent than to the impact of the actual death on the child.

Psychological disturbances in children after bereavement

Rutter[9] showed a connection between bereavement and psychiatric disorder in children. No studies, however, show what proportion of bereaved children are in fact disturbed. The death of a parent seems to have a delayed effect. Children who are bereaved in early childhood, but not in infancy, are most at risk, but emotional disturbance may not develop until adolescence. Rutter[9,10] points out that psychological complications appear to develop in children when a parent of the same sex has died. This may be because the child will have been deprived of a model of appropriate sex-role behaviour. It is relevant to add that most of the children's disorders mentioned by Rutter did not arise until well after the parent's death.

Mourning

Mourning is the emotional experience that follows bereavement, and, although the process of mourning in our society has become a private and solitary matter, grief has to be expressed. The immediate stage between the death and the acceptance of the loss has to be worked through if the bereaved person is not to suffer from prolonged disturbance and permanent damage. Freud[11] emphasised the "work of mourning," when a bereaved person has to experience feelings of grief, loss, and guilt. He omitted to point out that for a child, however, the absence of a parent may have as profound an effect on that child as death will have on an adult.

The stages of mourning are well documented and are as necessary to the mental health of the person as the developmental stages of early childhood. The initial stage is experienced as numbness, followed by a stage of anger. Searching for that which is lost may then be followed by a stage of denial. Anger, searching, and denial may well alternate with each other during this period of mourning. Finally, there is the stage of acceptance when the anger has gone, the searching ceases, and the denial subsides. Although the stages are easily recognisable, they are seldom clear cut, for one stage may merge with another. But when the final stage has been reached the person can start to think of a new pattern of living and progress towards regrowth.

The recent findings of Bowlby[12] suggest that, when a bereaved child has reached the stage of making a new relationship, that child should be encouraged to retain the memory and the image of the dead person. This will be of practical help to all concerned, for evidence shows that any new relationship is more likely to succeed and to prosper if the child can keep the two relationships quite distinct, one from another.

Individual reactions to grief will differ widely, and they will not always fit into the conventional pattern. Hinton[13] states that, "personality alone does not allow us to anticipate how people will be when they are bereaved; it is the nature of their relationship with the deceased which appears to be more significant." It may be suggested that the death of a young child does not have the same effect on the parents and on the siblings as the death of a young adult. Death in early adulthood, when the life has been unfulfilled, may bring intolerable distress to the bereaved. Unexpected deaths, some of which may be both tragic and violent and are often referred to as "accidental," claim the lives of many people in every age group. But it is when these sudden deaths occur to young people between 18 and 25 that the greatest traumatic effect can be expected on the bereaved, for they may believe that such deaths are both unnecessary and untimely. The death of a person who has completed his span of life, however, may be more easily accepted by the bereaved families.

The death of a child's parents is always untimely. As Bowlby points out,[12] the parent may still be young or in early middle age and the death is likely to be completely unexpected. Such deaths come as a shock to each generation of survivors—the child's, the parent's, and the grandparent's—and each will experience a shattering of their hopes and plans. When death does come, however, whether it is untimely or in the fullness of time, the bereaved can be helped to work through the process of mourning. It is useful to remember that the reason for mourning is not to forget but is to accept the reality of the loss and to live with the knowledge that death is final and irrevocable.

How can adults help?

Death is inevitably a normal part of children's everyday life. All children witness the changing seasons, and they learn about the cycle of life and death in the natural world. Many children meet death for the first time when a family pet dies. They cannot be shielded from these events, although many children will be bewildered by them. At such times children need to be free to express their feelings and to share their thoughts. Young children have no difficulty in talking about death, perhaps because they cannot disentangle fact from fantasy. But for many adults in our society death is not an easy subject. In other cultures throughout the world people believe that they should live their lives in the constant awareness of death and their goal is to die consciously.[14] To obtain such an understanding of the relationship between life and death appears to have eluded many in Western civilisations. This has resulted in many parents and teachers excusing themselves from teaching the facts of life and death to children because they believe that children are too young to understand. Recently, however, more adults have attempted to help children understand gestation and birth, yet there is a temptation to be equally assiduous in shielding them from the impact of death.[15] Children should be encouraged to talk freely about being born and about dying and death. They need to express their fears and fantasies to someone who can listen. Parents may not always be able to do this after a death, because it appears that the behaviour of the parent is dictated by their own inner needs rather than by a realistic appreciation of their children's feelings. Wolff[3] suggested that only when parents are helped to master their own often conflicting feelings in the face of death will they be able to adopt realistic and helpful attitudes towards their children. Children also have to come to terms with changes in the pattern of their lives. So they must likewise pass through a period of grief.

Health professionals, teachers, and other caring adults have a vital part to play at such times, and everyone should help

children who are in the midst of bereavement to work through their loss, stage by stage—by being both sympathetic and honest, particularly the latter. Adults whose aims are to help bereaved children must give up the pretence that life is unchanged. Children will respect the person who refuses to act out the charade of denial. We must encourage children to talk about death because silence deprives the child of the opportunity to share his grief. We must learn to listen and to respond by letting children know that we understand what they are trying to say. We must not offer final answers to children because there are no such answers to give. If, by working on this basis, we can accomplish these aims we may be able to bring solace and some understanding to children who mourn.

Epilogue

Death is perhaps one of the few remaining taboo subjects. If this were not true why is the subject seldom found in the school curriculum ? Teachers and other adults may believe that children need to be protected from the facts of death, but perhaps it is their own fears and attitudes that prevent them from mentioning the subject. Children like to talk. But if they are not encouraged to take part in discussion and if their questions remain unanswered how are children to learn ?

The average child is very tough and resilient and can cope amazingly well with bereavement, even with the death of a parent, so long as adequate subsequent care is provided. Brown[2] comments that "death and the relief of bereavement, mourning, and deprivation are at the centre of most religions of the world and the appropriate handling of these problems is an important step towards the improvement of mental health." Perhaps it would be better if these subjects could find a "resting" place within the context of health education. Then death, bereavement, and mourning could be dealt with by doctors, nurses, other health professionals, and teachers. If these people are actively concerned in child care they will know that the creed and the colour do not matter, for children are just children, and their needs are the concern of us all.

"Any man's death diminishes me, because I am involved in mankind."
—JOHN DONNE 1572-1631.

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Personal Paper

Labile hypertension and jogging: new diagnostic tool or spurious discovery?

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Abstract

A labile hypertensive black man reviews his own personal history of hypertension, based on intensive self-study. The evidence suggests that aerobic isotonic exercise (jogging) depresses labile pressure values, forcing them down to near basal levels and preventing a rise to previous blood pressure levels for several hours.

Introduction

During a routine medical examination on 3 September 1975, I learnt I had high blood pressure (178/100 mm Hg). A diagnosis of "essential hypertension" was not unexpected in a patient who was black, 44 years old, unemployed, and spending 12-15 hours a day writing a doctoral dissertation in a tiny rented room in Harlem. Yet despite being mindful of the denial syndrome, I simply could not dismiss a lifetime pressure reading of 120/70 mm Hg—a reading that only four months earlier had been verified by a doctor. I neither drank nor smoked, faithfully jogged about 4·84 km (3 miles) a day, my resting pulse was 47 and serum cholesterol concentration 136 mg/100 ml, and I averaged seven hours of sleep a night. Nevertheless, my doctor had no choice but to prescribe drugs (alpha-methyldopa, 500 mg, and triamterene, 100 mg, daily).

The treatment was effective for several months, but then I noticed incremental rises in my blood pressure to 150/102 mm Hg and increasingly severe side effects.

After consulting my doctor, I abandoned drugs and began a new regimen based on dietary regulation and aerobic exercise. I also maintained a record of home blood pressure readings. The distribution of my readings in my doctor's office tended toward the high side but was counterbalanced by my lower home readings. Once again my diagnosis was changed, this time to "labile hypertension."

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